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“As a community, we need to be more health conscious”: Pastors’ perceptions on the health status of the Black Church and African-American communities

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Abstract

Background—Churches are recognized for their potential capacity to provide health services and interventions to address health disparities in African-Americans (Blacks). Since Pastors are central community leaders, their support and involvement can influence both implementation and outcomes for church-based health programs. The purpose of this qualitative study was to explore pastors’ perceptions of congregant health status within the Black Church.

Methods—Semi-structured interviews were conducted with 11 pastors whose female congregants participated in a physical activity intervention. Thematic analysis techniques were used to analyze interview data.

Results—Three major themes emerged: 1) health risks in the African-American community, 2) health promotion in the Black Church, and 3) the importance of women in the Black family and the church. Pastors noted numerous health disparities affecting their congregants and the African-American community at large, including obesity and infant mortality. They viewed health holistically and included faith in their perspectives. According to pastors, holistic health was promoted through health ministry programming in Black churches. Women were described as the

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Connectional church is a term in the Christian Methodist Episcopal (CME) Church and other Methodists which refers to the unity and interpersonal relationships between clergy, members, ministries and with other churches in the denomination.

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cornerstone of the Black Church, yet faced unique health concerns from their roles as family caretakers and congregants.

Discussion—Pastors shared their major concerns for congregant health status and the African-American community. Health interventions focusing on African-Americans in church settings should include pastor involvement and should incorporate holistic approaches to address health risks.

Keywords

Health Disparities; African-American; Religion; Spirituality; Exercise; Minorities

Introduction

Regardless of health care improvements, African-Americans (Blacks) experience persistent health disparities compared to other ethnic or racial groups in the United States (Lekan, 2009), which includes having disproportionately higher rates of chronic disease in comparison with the general population (Pleis & Letheridge-Çeky, 2007). For example, African-American adults experience disparate levels of morbidity and mortality and report lower health status compared to Whites and Hispanics (CDC, 2014a, NCHS, 2016). At the root of health disparities in the African-American community are many complex factors at multiple levels which make these issues very difficult to resolve (Noonan, Velasco-Mondragon, & Wagner, 2016).

Researchers have investigated the role of church-based programs in addressing health disparities experienced by African-Americans (Abara, Coleman, Fairchild, Gaddist & White, 2015; Tussing-Humphreys, 2013; Wilcox et al., 2013; Santos et al., 2017). The Black Church has historically been a very important and highly trusted institution within the African-American community (Camara, 2004; Lincoln & Mamiya, 1990). As an integral part of African-American society, the Black Church has been influential in contributing to the social, economic, and political welfare of both congregants and the local community (Lasater, Becker, Hill, & Gans, 1997).

Because of their influence, pastors in the Black Church who communicate messages about healthy behavior can play a vital role in the success of health promotion programs that focus on African-Americans (Lumpkins, Greiner, Daley, Mabachi, & Neuhaus, 2013). Moreover, former studies specifically indicate that pastors can be influential in encouraging church members, such as deacons and health ministry volunteers, to support health programs (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Young & Stewart, 2006).

The aim of this qualitative study is to contribute to the limited body of literature on pastoral perspectives of their congregants' health (Timmons, 2009) by exploring pastoral perceptions on health status within the Black church and broader community.

Methods

Study Design

The current study utilized a qualitative approach to conduct individual interviews with 11 pastors whose congregants participated in an interview study evaluating the *Learning and Developing Individual Exercise Skills (L.A.D.I.E.S.)* for a Better Life study (Author et al). The interview study used a phenomenological design to elicit descriptions and interpret the pastors' perceptions of the L.A.D.I.E.S project. It also allowed pastors to individually consider the health status of their congregations and community in the context of L.A.D.I.E.S. Secondary qualitative analysis was conducted to analyze existing data from pastor interviews for the L.A.D.I.E.S. intervention. According to Heaton (2004), secondary qualitative analysis involves an in-depth investigation of the qualitative data gathered in a primary study. The authors conducted the secondary qualitative analysis to understand and interpret the pastors' perceptions on the health status of their congregants and the Black community.

L.A.D.I.E.S. Study

The L.A.D.I.E.S. study examined strategies for increasing and maintaining physical activity levels among low active African-American women (Author et al.). Churches (n = 31) that self-identified as predominantly African-American congregations were recruited and randomized as "clusters," to participate in one of three interventions: 1) a faith-integrated (FI) physical activity program, 2) a non-faith-integrated (NFI) physical activity program, or 3) a self-guided program (control group). Church denominations represented in the study were: Baptist (n = 14), Nondenominational (n = 11), African Methodist Episcopal (n = 3), Christian Methodist Episcopal (n = 1), Pentecostal (n = 1) and Seventh-Day Adventist (n = 1). Participants (n = 12–15 women per church) were recruited within the involved churches. The study was based in a suburban community in North Carolina. Participating pastors signed a "covenant agreement" indicating their knowledge and support of their church participation in the L.A.D.I.E.S. program. However, pastors were not directly involved in intervention activities. Further detailed methods for the L.A.D.I.E.S. intervention have been published elsewhere (Author et al.). Upon intervention completion, an interview study was conducted with pastors to explore their perceptions of the program (Author et al). Additional details of the primary interview study are presented here.

Recruitment

Pastors whose churches participated in the L.A.D.I.E.S. intervention study were recruited for in-person interviews at the end of the research project (i.e., 22-month follow-up) by telephone. Of the 31 pastors invited, 20 declined participation for various reasons, including not being available or interested, feeling unqualified to be interviewed due to limited involvement in the L.A.D.I.E.S. study, or the current pastor was not involved in the initial decision to participate in the L.A.D.I.E.S. study.

Interviews occurred at a mutually agreed-upon location. Pastors received a small honorarium for participation in the current study. All procedures performed involving human participants

were in accordance with the ethical standards of the Copernicus Group Independent Review Board.

Interview Procedures

Two doctoral-level interviewers were trained via conference calls and webinars. Both interviewers were African-American men and novices to qualitative research employed through the original parent study, L.A.D.I.E.S. Pastors in the study were advised prior to the interview that their involvement was voluntary and they could end the interview at any time without penalty. Informed consent was obtained from all participants included in the study. Informed consent included an agreement to participate in the interview and audiotaping. Interviews lasted between 20 and 45 minutes, depending on length of pastors' response to questions. Pastors were interviewed using a semi-structured interview guide, which allowed the data collection process to be conversational. The interview guide contained seven main questions ranging from pastoral involvement in the L.A.D.I.E.S. study, what they would change about the program, and how the program changed the participants and also their church climate. (A complete copy of the interview guide is available in Author et al). Specifically related to the current study, interview guide questions sparked rich descriptions of congregant and community health concerns. All interviews were audio- recorded, transcribed verbatim, and then verified for accuracy. Confidentiality procedures included removing all identifiers from the transcriptions, securing audio files and transcripts in a locked location, and allowing only authorized project personnel access to the data. To guarantee anonymity pseudonyms were assigned to each participant.

Data Analysis

Thematic analysis was used to identify patterns within the data (Braun and Clark, 2006). After initial review of each transcript, two researchers (TG and CS) developed the codebook used in data analysis, guided by methods outlined by Fonteyn (2008). These two researchers also independently coded each transcript and described the relevance of each coded passage to the research questions in brief memos (Groenewald, 2008). After initial coding, repeating concepts were grouped into categories to generate themes (Auerbach & Silverstein & 2003). Through team analysis, the number of categories or themes was collapsed and refined to best reflect what the pastors reported. In building themes, the research team considered the socio-ecological model (Bronfenbrenner, 1994) since responses related to the community, church (organizational), and interpersonal (family) level. The research team's duties were 1) to identify exemplars that captured the pastors' perceptions and 2) to avoid researchers' biases and assumptions (Hill, Thompson, & Williams, 1997). The research team discussed and acknowledged differing perspectives on themes. Where disagreement arose, the team engaged in a consensus process to reach the final themes (Hill, Knox, Thompson et al., 2005).

To reduce bias, an external auditor separately analyzed the data. An external auditor with extensive qualitative experience, limited knowledge of the original L.A.D.I.E.S study and no connection to the current study examined the themes and assessed their accuracy. The independent auditor was used to establish inter-rater reliability. The roles of this independent auditor were 1) to confirm that multiple perspectives of the data were considered, and 2) to

ensure that the research team biases did not influence the findings (Hill, Knox, Thompson et al., 2005; Hill, Thompson, & Williams, 1997). Upon completion of the auditor's review, the research team met to discuss the auditor's themes. The auditor's feedback, if appropriate, was reviewed and incorporated into the findings. Disagreements about the themes were resolved through discussions and referring to the transcriptions until consensus was reached (Creswell, 2013). To enhance the rigor of the study, the authors used multiple data coders, wrote brief memos during data coding, used an external auditor, compared data with empirical literature, and used peer validation of data (Richards, 2002; Given & Samure, 2008).

Results

The convenience sample consisted of eleven pastors (35%; 11 out of 31). A range of 1 to 10 is considered acceptable for in-person interviews (Creswell, 2013). Most the pastors (91%, 10 out of 11) interviewed were men. One session included the pastor and his wife. Due to the makeup of this suburban, close-knit community, the study did not collect demographic characteristics for pastors to protect confidentiality.

Pastors provided their perceptions of congregant and community health behaviors and shared how their church addressed health issues during the interviews. Three major themes emerged from the data based on the socio-ecological model: 1) health risks in the African-American community (community level); 2) health promotion in the Black church (organizational level); and 3) the importance of women in the Black family and church (interpersonal level).

Health Risks in the African-American Community

Ten pastors consistently shared their perceptions on the general poor health of the African-American population, including how chronic conditions have impacted both their congregants and community. Overall, the discussions of health were negative and focused how poor community health leads to poor health in the church.

Health Disparities—Several pastors highlighted a myriad of health risks existing among their members and in the community, with eight referring specifically to the relationship between food and poor health. Pastor Arnold referred to the overall disproportionate burden of chronic illness that African-Americans experience. He lamented:

We need to continue programs and studies that deal with African-American health because by the time this population get sick with diseases it's always at the most extreme form in terms of its development and that's on most every account. So, I think as a community we need to be more, you know health conscious and be able to know the symptoms and just education in general I think it's imperative. (Pastor Arnold)

In addition to the disproportionate burden of disease, other pastors expounded on particular health issues of importance in their communities:

Because in this community we have lot of people with diabetes ... lost limbs because of their eating habits so, as a church, it behooves us to do something ... not just sit in these walls and do nothing. (Pastor Bart)

So many of our African-Americans don't get enough exercise and activity ... We got a lot of our ladies who perhaps would be considered overweight/obese, and when you get to a certain age you're not doing anything and [when] you continue with your normal eating habits, [and] eating preferences, the risk becomes greater for obesity, for health issues, hypertension, diabetes, things of that nature. (Pastor Conrad)

In contrast to chronic disease and lack of physical activity, Pastor Bart's wife mentioned infant mortality. In her description, she illustrated how health issues, such as infant mortality, impact not only African-American women but their families and the broader community

Yeah, infant mortality ... I work with parents ... [I] teaches them about ... not smoking, and other healthy habits, that [can prevent] our babies to be born too early ... We've had to do funeral services for some of the babies ... and that's not a good feeling. When they die, it just doesn't affect the mama and daddy, [but] it does affect the whole, the sisters and brothers, and grandmamas and everybody. It affects a whole community ... And stress is one of the biggest that causes ... infant mortality, the woman to lose a baby. (Pastor Bart's wife)

Despite previous discussions of health risks in the African-American community, Pastor Dwayne noted positive behavioral lifestyles among the younger generation:

This younger generation, [at least] a good portion of them, are more conscious of trying to stay in better health. I see that ... For example, I don't see as many young people smoking as used to ... I'm 60 so I'm going back several years. What I used to see and what I see now. I see y'all, your age group trying to adopt some healthier lifestyles. (Pastor Dwayne)

Health in the Black Church—Health risks existing in the larger African-American community are parallel to those in Black churches. Interestingly, pastors described a disconnect between faith and health, meaning that faith did not always translate to good health and healthy lifestyle behaviors.

Where I come from, I know that we haven't always taken health seriously. You know we're good at preaching the gospel but ... like I tell folks ... it's nothing in the Bible about smoking. No, it doesn't talk about cigarettes directly but it talks about defiling the temple. However, if you keep smoking, you're just going to go where you're going quicker. You're just going to leave here quicker, I'm not fixing to sit up here and tell you [to] quit smoking. No, you know that it's not healthy, and, anything that's not good for you, then don't do it. (Pastor Evan)

Similarly, Pastor Freddie mentioned,

It takes discipline to exercise and though the church ought to be filled with disciplined folk it often is not. So, they find a reason why not to exercise, and they ... Why do we have to exercise? If we get sick, we can just pray. The Lord will heal

us (laughing) ... Doctor say don't eat this [because] it's bad for us, we eat it then pray the Lord will ... and so, you know, there's that dynamic of faith, over against reality. (Pastor Freddie)

While describing the health status of the Black church, the pastors mentioned that they included themselves as being "unhealthy." Pastor June considered himself as being "a big fella" and "obese" while Pastor Evan took medication for his chronic illness. These individuals acknowledged that they "needed to get back into shape." In addition, two pastors discussed the premature deaths of fellow pastors and women dying before men in the church.

In the African-American church, when we're studying, doing studies, and implementing studies, look at how many people die in the church that the world on different types of...what is, what is what's causing them to die faster in the church? ... If you look at the pattern, at the system how the church is run, who dies faster? The second one is the pastor, behind the women. (laughing) Like for instance, the rate of I think 7 to 1, women die faster in the church than men. In the church, not the world, but the church. You see the pattern? ... Church should not be that stressful. Church should be a joyful place, a healthy place. (Pastor Gladys)

Promoting health is not something that is commonly practiced in Baptist churches. And certainly, it hadn't been practiced here as far as exercise, good eating habits. My predecessor was at this church 17 years, and he died when he was 45, and he was extremely overweight. (Pastor Freddie)

Pastors, as leaders, realized the importance of modeling good health to their congregations. Pastor Bart shared making dietary changes to improve his health:

One reason we did a drastic change was every time I would go to the doctor, he would fuss at me about my numbers: blood pressure, cholesterol ... so I just got tired of him fussing at me. That's why I said, 'I'm gonna change my eating habits.' I changed my eating habits, and went back to him, my six-month, my three-month checkup, all my number were great ... So, as a pastor, it was no way that I could have my numbers bad, and then tell other people you need to get healthy and all that. I had to show them, what healthy eating and all this could do for them. (Pastor Bart)

Health Promotion in the Black Church

Throughout the discussions, eight pastors defined their own view of health and how their perspectives influenced the health education and programming for their congregations.

Holistic views of health—Pastors continually described having a "*holistic*" view of health, which included physical and spiritual components of health working together toward a healthier lifestyle. They supported their viewpoints with Bible passages, such as the body being a "temple."

We're certainly trying to be more health conscious, as a church body as well as African-Americans ... We do have to be more health conscious and support those

outside agencies that will help us, partner up with them to bring about more health awareness into the church. And, while it's not a direct mission of the church, because our mission is Jesus Christ and Him crucified, it does tie in with having a healthy temple ... that God can dwell within (Pastor Evan)

Several of the pastors included terminology such as “faith,” “discipline,” “quality of life,” and “being health conscious,” to describe their holistic views of health behaviors, which include exercise, healthy eating, coping with stress, abstaining from substance use (i.e., smoking). The importance of sleep was another aspect that emerged from one interview.

We encouraged them to go to their medical physicians, encouraged them to look at what they eat, encouraged them to look at what they drink. We, definitely encourage them to pay attention to their sleep pattern. Because you and I know that the body has a fuel system to it, and when you're sleeping, fuel is going to burn to try and regenerate the body to health. (Pastor Gladys)

The pastors' holistic view of health extended beyond the individual level to interpersonal levels, such as family and community members. Pastor Conrad described the importance of family meal times for healthy eating, and he concluded that healthy nutritional habits needed to be passed down from one generation to another.

Just like when we cooked, previously, it tasted wonderful, but it wasn't always the best for us. So, the children were also beneficiaries of the bad habits. Hopefully, as we become educated, as we begin to see the fruits of the effort, our children will also benefit and reap the benefits. (Pastor Conrad)

When adults learn how to improve their health, children in turn also benefit from this new knowledge and learn new health habits from their parents and other adults in their lives.

Current health ministries—Many the pastors' churches (7 out of 11, 64%) had a self-reported well-established health ministry, while three other pastors (27%) described starting new health ministries because of participation in the L.A.D.I.E.S. study. Health ministries were generally viewed as organized health promotion and disease prevention efforts that are faith-based, thus include prayer and foundations in Bible scriptures. Activities occur within churches for congregations and often their greater communities. Seven pastors described how their health ministries promoted holistic health and wellness. Pastor Arnold, who described himself as a trained psychotherapist, offered mental health programs and a “cancer support group” within the religious institution.

Pastor Gladys believed that “church should be a joyful place, a healthy place”, also has a holistic health program. Such programs seem to be an effort to increase knowledge to empower congregants to improve their health.

We have a health component in our church. I do health seminars [or] was at least doing them every year ... And we will do another health seminar next year ... A national health person ... a radio personality, television personality, and he came in and spent two days with us, in our health seminar. But also ... we talk about God's Garden, we talk about food, how to eat the food. We look at what causes stress in

the Afro-American church. And we tried to give people an opportunity to build their knowledge. (Pastor Gladys)

Pastor Bart, who focused on his congregants practicing healthier eating behaviors, received a state grant to start a health ministry. Their health ministry focused on variety of issues including infant mortality, and nutrition.

We also have a communion to God every year—with vegetables to cook—to show the people you can cook vegetables without loading them down with grease ... Then use olive oil and use herbs to season with. My people cook with pork and ham hocks often, but you can make food taste good without all that. (Pastor Bart)

Similarly, Pastor Harlow described the health-promotion activities around nutrition and physical fitness.

We do have an active lifestyle, exercise, [and a] healthful living combination ... What is called quarterly lifestyle, it's called Fresh Start ... We bring in information as to what type of exercise we've done for that time ... The few months, miles we walk and stuff. And then we actually have for that day ... we actually have a vegan, vegetarian cuisine ... that's done and it's demonstrated ... So, people can actually go back and learn how to receive that as a church. (Pastor Harlow)

Lastly, Pastor Ivan incorporated *Instant Recess*®, a 10-minute workout program included during the weekly Sunday worship services. One of his church members is a coach at a local university and leads the exercise program. He proudly described the program:

We have the instant recess as a part of our worship service every Sunday. We have a coach ... And you know he works at [local university]. He's really the one. [He] really comes up with, sets the agenda for that Sunday morning. And then whatever the activity during that instant recess period, that is their assignment for the next seven days along with what they're doing with any other programs they are involved in. So, it's definitely made some tremendous, you know, impact upon you know the lives of our church. And we have people of all age levels who participate. (Pastor Ivan)

Importance of Women to the Black Family and the Church

Given that the parent study (L.A.D.I.E.S.) focused on increasing physical activity for the female congregants, the pastors articulated the importance of the intervention. Not only do African-American women face a myriad of health issues, they also play a vital role in the health of their family and the Black church. Therefore, having, a focused intervention program for women improved the health of the family and the community as a whole. Five pastors discussed the role of women in some capacity, ranging from their general importance to the church and/or family to the influence of pastors' wives in implementing the L.A.D.I.E.S. study.

Pastor June, who had served at several different churches, frequently mentioned the role of women in the Black church:

Women seem to be the backbone of the church these days ... But most of my findings, especially in the last few churches, that I have observed, women are usually in leadership roles. It seems that men have a problem with leadership. Especially when there's a male pastor, okay? ... Women on the other hand, you know, they speak their mind, they're emotional, [and they] are therefore more truthful ... We at our church have an organization called the Women's Missionary Society. Okay and it's predominantly, you know ... is women. That's part of the connection—the fact that the person was the connection or leader is one of the general officers of the main leaders of the CME church. So, the women's missionary society, and that's, to tell the truth, that's basically how I looked at it ... through the Women's Missionary Society. Um, they do, they again, I use that word, been a backbone of not only the local church but even the connectional church.*
(Pastor June)

Pastor Conrad acknowledged that by prioritizing women, the L.A.D.I.E.S. health intervention was an investment in family health.

How these things play in the family structure? Children starting out ... if mom or grandma has already begun to make changes, and improvements, then the children are going to be the beneficiaries of the new knowledge. (Pastor Conrad)

The female pastor, Pastor Gladys, shared her perspective on the role of women in the Black church by describing the downside of being women. She described a situation in which women overwork and overextend themselves physically to serve the church, and their families.

As an African-American woman and as a female pastor, what I will say to you is that women in church they don't ever want to be seen in church as being wasteful ... They're serious; they have a serious relationship with God by the productivity of what they do in the church, in their mindset. But then, that's not the way it's supposed to be. Works are not what's going to get you into heaven. Now, take that and go back to my previous statement, you understand why they die faster ... But usually women carry it all, they carry it home, they carry it in their life, it becomes, they carry it all of their life, running the church. They neglect themselves. (Pastor Gladys)

If African-American women are the “cornerstone” for their churches and families, their health status is important for their caretakers and church members. However, African-American women focus much of their time and energy caring for others within their church and less on their own health and well-being. Thus, health interventions are an opportunity to empower African-American women with knowledge to improve their health through physical activity and other positive health behaviors.

Discussion

Pastors within the study described their perceptions of the health of the community surrounding their church, the congregants in the church and the church health ministry. Our findings identified three major themes: 1) health risks in the African-American community,

2) holistic health promotion in the Black church, and 3) the importance of women in the Black family and the church. The discussion is organized according to a central area of concern emergent from the themes: the relationship between religion, health and culture in the African-American experience.

Health risks in the African-American community

Current study findings extend the discussion on religion, health and culture within the African-American experience. Religiosity, including church attendance, is generally thought to be associated with positive health outcomes (Koenig, King, & Carson, 2012; Krause, Shaw, & Liang, 2011). African-Americans traditionally have high rates of church attendance (Pew Research Center, 2009). Yet African-Americans continue to experience increased health risks according to pastors in the current study. Health risks are confirmed in the literature, as 56.9% of African-American women and 37.6% of African-American men are obese; 44.8% of African-American women and 40.9% of African-American men have hypertension, 17.5% of African-Americans have diabetes, and the infant mortality rate is 11.11 per 1000 live births among African-Americans. All rates for African-Americans are higher than their White counterparts (CDC, 2014b). However, it is important to note that positive health outcomes among regular church attendees are mediated by positive health behaviors (Musick, House & Williams, 2004). Several themes addressing the relationship between religion and health behaviors emerged from the current study, including the need for holistic health approaches, the role of women in the Black church and pastoral health status.

Holistic Health

The frequent mention of body, spirit, and mind by pastors confirmed the need for holistic models in order to address health beliefs (Hotz, 2015; Black, Gitlin, & Burke, 2011; Woods-Giscombé & Black, 2010). The PEN3 model, as designed by Airhihenbuwa (1990), regards points of culture as places for intervention (Iwelunmor, Newsome & Airhihenbuwa, 2014). According to PEN 3, health decisions are made within a cultural context. Cultural empowerment, as described by PEN 3, is a type of collectivism, in that people tend to follow the social norms and expectations of others within their cultural group. Collectivism can be positive if expectations lead towards positive outcomes. In the current study, pastors indicated that young women are starting to provide positive social support to older women for healthier lifestyles, which could lead to positive outcomes for future generations. In contrast, cultural empowerment could be negative, if the norm is to pray for healing instead of also engaging in health-promoting behaviors (e.g., physical activity). There is a need for positive expectations and cultural empowerment, as demonstrated through the presence of church health ministries and pastors' requests for community programming.

About health ministries, an overarching theme was a need for preventive education. According to the literature, pastors who believed in self-determination for congregants (Webb, Bopp & Fallon, 2013) were more likely to have health and wellness activities present within their churches. Most churches in the current study reported having health ministries, which could have influenced their decisions to participate in L.A.D.I.E.S. and the post-program interviews. Study findings are concurrent with the literature in that pastors

expressed the need for intentional partnerships between the church and community. Such partnerships can address health risks and build on current ministries (Carter-Edwards et al., 2012).

Nutritional Choices

Nutrition education was a primary component of health ministries in the current study and is a health concern for Black churches (Carson et al., 2015; Tussings-Humphreys, Thomson & Onufrak., 2015). Pastors in the current study interpreted traditional food preferences as poor eating habits among congregants and the general community. Cultural reasons for this may include parishioner perceptions that eating “healthy” conflicts with traditional soul food choices (James, 2004). The tradition of soul food in the African-American community is an integral part of culture, embedded in traditions of food preferences, preparation and church fellowship (Airhihenbuwa & Kumaniyaka, 1996). In a study related to food preferences, respondents were aware of potential negative components of soul food, such as excess fat and salt (Airhihenbuwa & Kumaniyaka, 1996). It is interesting to note that perceived poor eating habits identified in the current study are in contradiction to a study by Holt, Clark, Debnam & Roth (2014) in which religious involvement was associated with higher vegetable consumption in African-Americans. It may be that eating habits are dependent on community culture and types of religious involvement. For highly involved congregants holding multiple leadership roles, healthy eating habits and other forms of self-care could become secondary to taking care of the church.

The Role of Women in the Black church

Pastors were hopeful that younger women would begin new traditions of health and fitness, passing it along to their families. As leaders in the Black church, women have the ability to greatly influence health for themselves, families, and communities. Several pastors specifically referred to stress embodied by women as they care for both the church and their families. Cultural norms were thought to be a contributor to deleterious health behaviors and burnout among over worked female leaders, referred to as the “backbone” of the Black Church by both male and female pastors in the study. The idea of being “productive” and not “wasteful” as mentioned by a female pastor, could promote continuous work at the expense of emotional and physical health.

Perceived productivity may contribute to stress related co-morbidity and chronic disease seen within the African-American community. Literature confirms that the overall physiological burden of disease is highest in African-American women, even when controlling for poverty, especially by the age of 45 (Geronimus, Hicken, Keene & Bound, 2006). Disease burden reflects the idea of “carrying it all,” meaning the need to care for family, church and community, while sacrificing personal well-being. The assumed sacrifice of caring for others places African-American women at a higher risk for stress-related disorders (Hamilton- Mason, Hall & Everett, 2009). Unfortunately, placing self above others can be viewed as selfish within the community (Woods-Giscombe, 2010; Beauboeuf-Lafontant, 2007). With the support of pastors, the historical paradigm of “carrying it all” could be replaced with purposeful self-care, as seen in some younger generations through physical activity.

Pastoral Health

The literature suggests that faith-based programs can be effective in changing health behaviors (Lancaster, Carter-Edwards, Grilo, Shen, & Schoenthaler, 2014; Bopp, Peterson, Webb, 2012; Campbell et al, 2007). Although there is limited evidence of pastoral influence on parishioner health, the literature indicates that pastors are effective change agents due to the nature of their position (Lumpkins, Greiner, Daley, Mabachi & Neuhaus, 2013; Bopp, Baruth, Peterson, & Webb, 2013). To our knowledge, few studies explore African-American pastoral health and the impact on role model perceptions (Rowland & Isaac-Savage, 2014; Harmon, Blake, Armstead & Hébert, 2013). Some of the pastors within the current study recognized that their personal struggles with health habits and chronic disease are like those of the community. Clergy health concerns are reflected in the literature, including obesity, diabetes and stress related hypertension (Proeschold-Bell & LeGrand, 2010; Baruth, Bopp, Webb & Peterson., 2015). Pastors in the current study desired to function as effective role models for their congregation and community. Concurrent with the literature, pastors who identify as role models tend to seek proper nutrition and self-improvement (Harmon, Blake, Armstead & Hebert, 2013; Carroll, 2006). Future congregant health interventions should include appropriate components for pastoral health, with active support from congregants. Overall, pastors realize their potential to influence health behaviors of their congregants and the community (Churchwell & Schaffner, 2011; Cohall & Cooper, 2010; Timmons, 2009; Levin, 1986).

Limitations

Limitations to the study were potential for social desirability bias from the pastors involved in the study, small recruitment within the study population (i.e., 11 churches responded out of 31 churches in the study) and lack of representation of the study population (i.e., male pastors versus female congregants). One reason for the low participation could be that pastors who enrolled their church in the research project moved to other congregations before the study ended and the time constraints of the pastors in smaller churches (i.e., the pastors worked a secular job as well as pastoral positions). Regardless of the limitations, the current study adds to the literature by providing the pastoral perspectives of health and the African-American community, particularly the effects of church involvement on female congregants.

Conclusion and Implications

Findings from the current study have multiple implications for the literature and public health practice. Pastors are aware of health disparities and are concerned about their congregants and surrounding communities. According to the literature, their understanding of the intersection of health and faith is unique and is needed for successful interventions. Pastors can partner in improving health outcomes using national and church initiatives, such as: 1) The National Physical Activity Plan (2016), 2) Integration of health topics within sermons (i.e. "Eat Smart, Move More") (Eat Smart, Move More, n.d.), and 3) Integration of physical activity into church services (i.e. "Let's Move" and "Instant Recess") (White House, 2011; Instant Recess, 2013). As pastors become involved in faith based initiatives,

they serve as role models for their congregations and community. A positive implication for role modeling includes improved pastoral health.

In terms of gender roles, current study findings add to the literature on faith, stress and health among African-American women. Interventions will need to involve encouragement of self-determination and responsibility in female congregants. As an example, mindfulness meditation may assist in bridging the gap between faith and self-care, reflecting a holistic approach mentioned by pastors. Mindfulness interventions can help in understanding personal strategies and reactions to stress (Woods-Giscombe & Black, 2010). Pastoral support is needed to continue the cultural shift towards health among African-American female congregants, especially those in leadership roles.

An overarching theme from the current study was the need for culturally appropriate interventions in order improve congregational and community health. Multi-level community and church partnerships, including volunteers from different sectors of the community and multiple churches, are indicated in order to achieve a holistic level of health (Wilcox et al., 2010). The availability of multi sector resources and partnerships can also bridge resource gaps for African-American communities in areas of concern, such as nutrition.

The Black church (organizational), family (interpersonal) and community are interchangeable components of health ecology for African-Americans. Due to their influential role, pastors in the Black church are instrumental in the success of faith and community based health programs. Public health practitioners should dialogue with pastors in the planning, implementation and evaluation of faith based programs. The current study adds to the literature by exploring pastoral perspectives of African-American congregant and community health along with implications for health programming. By understanding faith based leadership perspectives, public health organizations can better partner with faith-based organizations to dismantle persistent health disparities.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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